Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN ANTONIO MEDICAL LSUPPLIES
1500 FREDERICKSBURG RD SUITE B
SAN ANTONIO TX 78201

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-4323-01

MFDR Date Received
JUNE 7, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier denied initial claims for no preauthorization. Appeal for reconsideration submitted stating preauth is required for amounts that exceed $500.00. The total amount did exceed $500, but each individual item billed did not. Our claims were reviewed and the decision to deny payment on our claim was based on the total amount. Please review all attached documentation and reconsider for payment."

Amount in Dispute: $1,105.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "2. Texas Mutual paid the brace and denied payment of the remaining items absent preauthorization approval for them. 3. The requestor argues that DWC Rule 134.600 controls reimbursement in this case because of section (p)(9). 4. Texas Mutual agrees that Rule 134.600 is controlling but at (p)(12), ODG does not address, for the low back, positioning cushions, gel pressure mattresses, semi-electric hospital beds, innerspring mattresses, bedside rails, trapeze bars, or the use of cold beyond the first few days of the acute stage of the injury. Rule 134.500(p)(12) states, '…treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols…' require preauthorization…"

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 270, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2009	Durable Medical Equipment	$1,105.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §133.100 sets out the procedures for Treatment Guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 930 – Denied in accordance with 134.600(P)(12) as the treatment/service is in excess of the Division's Treatment Guidelines as outlined in the Disability Management rules effective 5/1/07. Please refer to the Disability Management rules, Chapter 137 on the Division's website.
   - 197 – Precertification/authorization/notification absent.
   - 930 – Pre-authorization required. Reimbursement denied.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the services require preauthorization?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the treatment/services in dispute using denial codes 930 – "Denied in accordance with 134.600(P)(12) as the treatment/service is in excess of the Division's Treatment Guidelines as outlined in the Disability Management rules effective 5/1/07. Please refer to the Disability Management rules, Chapter 137 on the Division's website"; 197 – Precertification/authorization/notification absent; and 930 – "Pre-authorization required. Review of the Official Disability Guideline (ODG) for ICD-9 codes 722.10 and 724.6 for the above date of service finds the ODG does not address the use of the durable medical equipment specified in this dispute. Per 28 Texas Administrative Code §134.600(p)(12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier; therefore, preauthorization was required but not obtained by the requestor.
2. Review of the submitted documentation finds that reimbursement is not warranted.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services..

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 9, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.